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TESTIMONY BEFORE
HOUSE COMMITTEE ON PUBLIC EMPLOYEE HEALTH CARE
REFORM

November 5, 2009

Rick Murdock
Executive Director
Michigan Association of Health Plans

Good Afternoon Madam Chair and Committee members. Thank you for the opportunity to discuss with you our observations and recommendations regarding the overall issue of Public Employee Health Care Reform. My name is Rick Murdock and I am Executive Director of the Michigan Association of Health Plans. MAHP represents 19 health plan organizations that provide comprehensive health care benefits to over 2.3 million Michigan citizens from Commercial, Medicare and Medicaid products. Additionally, our members provide third party administration services for self-insured plans and county health plans services. We are proud of the quality and accountability of the services provided by our members that annually are ranked among the highest performing health plans in the United States. The most recently published rankings included five in the top 50 Commercial Plans; two in the top 25 Medicare Plans; and 11 in the top 50 Medicaid Plans. We expect this performance to again be recognized in the next ranking by the US News and World Report/NCQA report to be released shortly.

August 12, 2009 MAHP Letter

Soon after the release of the Draft Report on the Proposed Public Employee Health Care Reform, MAHP submitted a detailed letter with suggested areas of improvement. These areas included:

- Retaining Consumer Choice
- Equal Marketing Conditions and Assuring Competitive Process
- Migration of individuals from Small Group Customers
- Retention of Collective Bargaining

Our letter also addressed the purported savings from the proposal and the process to be pursued in further development. We continue to have many of the same concerns and due to other initiatives occurring at both the state and

federal level that argue for a need to proceed with prudence and caution.

While we believe that this proposal represents the “boldness” in looking at the core health care issues differently—a trait that other commentators have found refreshing, we do believe that much harm can occur without taking a prudent approach to enactment of any necessary legislation and its subsequent implementation. Therefore, we much appreciate the formation of this committee and look forward to the work that you ultimately will need to do to arrive at a sound conclusion and recommendations following the conclusion of all the hearings.

I would like to take the few moments today to address pertinent issues and concerns that we believe are critical to be resolved before finalization of this proposal and its companion legislation.

Current Concerns Regarding HB 5345

1. **Consumer Choice.** As we noted in our August 12th letter MAHP fully supports the greatest degree of consumer choice in health plan carriers coupled with true competition in the marketplace. While limiting the number of offerings that all carriers might provide for public employees may be appropriate, limiting the choice of carriers will be anticompetitive. We believe a choice of health plan carriers for consumers leads to a greater amount of competition in the marketplace and creates downward pressure on health care premiums. This high level of market competition is consistent with the efficiencies sought by the proposal to reform public sector healthcare.

As a result, a threshold concern for MAHP is that any proposal affecting public sector employees should assure that all health plans be allowed to compete for the public sector business. **It would be virtually impossible for MAHP to support a proposal that designates or unfairly favors any single (or subsection of the entire health plan market) health plan or health insurance carrier.** MAHP would propose the insertion of clarifying language in HB 5345 to assure this competition and consumer choice.

2. **True Competition.** Consistent with this discussion regarding consumer choice, true competition in the marketplace can only happen when all carriers are subject to the same market conditions. Another way of characterizing “similar market conditions” is to assure that no single carrier (or segment of carriers) has an unfair advantage in the market. This is especially true as it relates to provider reimbursement rates. If one carrier has monopolistic control over the amounts paid to health care providers, then it may pay minimal reimbursements and realize savings that are not available to any other carrier. This presents an inherently unfair market advantage by one carrier being able to leverage its control over reimbursements and essentially “freeze out” competition.

One method to assure fair market competition is to establish a common reimbursement fee schedule for your proposal to reform public sector health care. If all carriers are subject to the same payment rates to providers, then vigorous competition will flourish and public sector employees participating in the reform program will greatly benefit by

plans striving to provide the greatest quality of care. In that way public sector employees will be served by competition that is based on performance, quality and customer service. If HB 5345 includes competitive bidding, likely significant premium savings will result from the inclusion of a common reimbursement schedule.

It is already well documented that the public sector payers (Medicare and Medicaid) do not pay the full cost of services. This underpayment—coupled with the uncompensated costs from services for the uninsured result in what is now referred to as a “hidden tax”. (I have included as an attachment, linkage to the most recent report documenting these costs). It is estimated that more than \$800 of the annual premium paid by individuals each year is related to this “tax”. In Michigan this will be exacerbated further due to the Medicaid budget that was enacted over the past week that contained 8% provider cuts. The entire provider base in Michigan is affected by these changes—not just the Medicaid or Medicare providers. Providers attempt to make up the difference through capturing higher reimbursement from commercial carriers including those who would be likely to be carriers for the public employee benefit proposal.

Open and fair market competition is a principle that should be clearly set forth in any proposed legislation that may arise from this proposal and that provider reimbursement will be a prime focus of attention. MAHP urges lawmakers to add amendatory language to HB 5345 that will insure provider participation and create competition.

3. Limiting Participation to Public Sector. Opening the public sector employee option to those in the private sector can create perverse and unintended consequences. A migration from those currently covered under private coverage to the public sector coverage would likely also cause an undue financial burden on the state. As a result, the more immediate goal of a public sector employee plan should be limited to qualifying public employees. This would minimize “crowd out” from the private market that might occur by opening up the program to those who currently have coverage. Reports from the Insurance Commissioner indicate that the small market reform is working in Michigan as intended by the legislature. MAHP believes that any participation under the proposed public employee plan for employees in the private sector will diminish the population served under the small market sector and drive premiums and employee cost higher.

Therefore, we recommend that any discussion of inclusion of the private sector is premature and should not be pursued at this time. MAHP recommends that HB 5345 be amended to delete the opt-in provision for private sector employers.

4. Retention of Collective Bargaining. As we all know, collective bargaining has a long history in Michigan and it continues to play a large role in the purchasing of health care benefits in the group market, especially public sector groups. MAHP supports the retention of collective bargaining rights as a vital role for most local union representatives.

While we know this point has been raised by many others, we hope that clearer provisions will be included in HB 5345 to assure that collective bargaining rights will be preserved and will not be limited.

5. Cost Assumptions. MAHP has reservations about the total amount of saving estimates noted in that report and at what point in the process such savings might be realized. Regardless of actual savings realized, we caution that you should not assume that the projected savings will occur in time to be part of the FY 2011 budget deficit solution. Considering the time constraints in implementation of the program and working out of collective bargaining rights, it will be highly unlikely for the plan, even if launched in 2010, to have any appreciable downward pressure on short-run cost/savings.

Without repeating the analysis that was included in the Public Policy Associates, Inc. study that was released on October 19th, we share many of the conclusions from that assessment of cost savings. Further, as well documented in other testimonies that you have received, most of the public employee groups are already covered by Michigan's HMOs and PPOs that utilize various cost containment strategies and disease management/care coordination programs that are suggested in the proposal to create future savings. In other words—those savings estimated to occur have largely been realized.

One of the stated goals of the proposal is to “optimize the health of public sector employees, retirees and their families, by investing in prevention and wellness, rewarding healthy behaviors and encouraging individuals to actively participate in the management of their own health.” This goal accurately summarizes the core purpose of managed care plans and it is exactly what MAHP members perform on a daily basis. This experience of managing care makes MAHP member plans uniquely qualified to carry forward the purpose of the proposal for public sector health care and as I indicated at the outset, is what distinguishes the performance of our member health plans from others.

Further, the stated intent to “Establish a mechanism to ensure that the health care delivered in Michigan conforms to recognized best medical practices” is also an element already underway. MAHP members have been in the forefront of promoting evidence based medicine. This is more than a concept, it is a practice to actively use those methods and procedures that have proven medical benefits and clinical effectiveness.

While there may be other reasons to continue to pursue the public sector health benefit proposal—significant cost savings as outlined in the proposal are not a likely result and the exposure to additional costs as outlined in the Public Policy Associates analysis should be of concern to all.

Concerns Related To Other State Initiative(s)

1. Reform for Michigan Uninsured. This proposal also needs to be vetted in the context of other state initiatives and events. As many of you are very aware, MAHP and other

interested parties have worked with both the House Committee on Health Policy and the Senate Health Policy Committee to arrive at a consensus regarding affordable health care in Michigan. This was an outgrowth of the individual market reform debate from the prior legislative session. The emphasis is and continues to be on providing affordable coverage options for Michigan's uninsured population.

This point is important as the potential exists to implement "reform" through amendments to the state insurance code and Public Act 350 for assuring coverage for the uninsured that may be in conflict with potential amendments in legislation necessary for the public sector employee proposal. Further, the cost to carriers in implementing other reform may have a dampening effect on the ability to reach savings objectives—this would be in such undefined areas as reinsurance and premium subsidies that are under current review in the House and Senate Committees. Finally, there continue to be discussion regarding the establishment of various oversight committees, advisory boards, and other such mechanisms to provide future oversight of the reform initiatives.

It is in all of our best interest to assure that any reform package in Michigan is well coordinated and in concert with other initiatives underway.

2. Threat to Competition. Proposed Acquisition of Physicians Health Plan of Mid Michigan. Last month, the proposed acquisition of Physician's Health Plan of Mid Michigan by Blue Care Network was announced. This proposal is currently under review by the Insurance Commissioner. A public hearing on this acquisition will take place on November 23rd and we believe that information will be forthcoming to highlight the impact on competition that is likely to result if the purchase were to go forward. The impact on public sector employees, given the concentration of public employees in Mid-Michigan is significant.

We believe that if other groups are interested in preserving competition and choice in the Mid-Michigan market to maintain high performing health plans and assure price competition then they should join MAHP and others at this public hearing to raise these concerns.

3. Crains Detroit Business—Health Care Summit Solutions (Cost Containment)

One of the inherent flaws of HB 5345 is the absence of any significant cost containment initiatives. This concern has been raised about the other reform proposals at the state and federal level. So it is timely that we are now seeing some conversation on this issue. Most notably, several weeks ago, attendees at *Crain's* Health Care Leadership Summit were organized into 50 roundtables for small-group discussions to develop and arrive at a consensus regarding initiatives to pursue for cost containment purposes. The intent of the consensus issues were to be those that did not require state or federal reform to occur but could begin with the leadership within the health care industry—and if necessary with supporting state legislation or administration.

It was understood by that audience that simply attempting to re-arrange or alter the delivery of benefits will have little impact on the overall cost of health care and that cost containment has to be system wide and cannot be focused on a single setting or population group. Without getting into the details of the roundtable discussions here are the overall ideas that have now been published in Crains:

- **Idea 1:** Create an online health information exchange for Medicaid recipients that all doctors, hospitals, nursing homes, providers and insurers can access. Such a system could reduce duplicated tests and identify medical symptoms and diseases more quickly.
- **Idea 2:** Increase the number of primary-care providers, including physicians and such mid-level practitioners as physician assistants and nurse practitioners. Existing government programs to forgive student loans could be expanded and scholarships added.
- **Idea 3:** Expand wellness programs by providing financial incentives for employees to develop healthy lifestyles.
- **Idea 4:** Have the state of Michigan mandate health care price transparency as 40 other states have done. Armed with pricing and quality data, consumers would make better-informed decisions.
- **Idea 5:** Encourage doctors to adopt a “patient-centered medical home” approach by paying them more for electronic medical record systems, chronic disease registries and staff training.
- **Idea 6:** Use skills developed by auto industry engineers to improve efficiencies and streamline processes of hospitals and physician offices to improve quality and reduce costs.
- **Idea 7:** Mandate that all health plans reimburse hospitals and physicians at the same rates for the same services. Plans would compete on service and efficiency.
- **Idea 8:** Reduce overcapacity of acute-care hospitals, outpatient imaging and surgery centers. This could be done either by using a more aggressive Michigan certificate-of-need process, as New York State has done, or have each of the six hospital systems based in Southeast Michigan voluntarily close a hospital.

As an attachment to this testimony, I am including linkage to a report produced earlier this year for Americas Health Insurance Plans, AHIP, that highlights the impact of different cost drivers on the overall increase in health care premiums. **A key issue for this committee to address is the appropriate inclusion into HB 5345 of cost-containment initiatives that will provide the overall cost savings for this proposal.**

Concerns Related to Federal Reform Initiative

It is difficult to discuss any change in health care without placing it in the context of federal health care reform. As we well know both the U.S. House of Representatives and Senate are nearing the final stages of debate on health care reform. It is clear that several key decisions have to be made and an overall Senate/House conference report to be attained. However, most observers agree that federal health reform is not only very

likely, it is also apparent that the overall direction of the reform package will be established before the end of this year.

It is recommended that this committee pause before taking final action in order to assure that all recommendations will not be contrary to the requirements under federal reform—or indeed be unnecessary due to the federal reform package.

Recommendations For Public Employee Benefit Proposed Initiative:

1. All Health Plans (carriers) are permitted to compete to provide public employee benefits.
2. The proposal must include a principle of “open and fair market competition” and provider reimbursement will be a prime focus of attention.
3. Any discussion of inclusion of the private sector is premature and should not be pursued at this time.
4. Clear provisions will be included to assure that collective bargaining rights will be preserved.
5. Assurance that any reform package for public employee benefit programs in Michigan is well coordinated and not in conflict with other state and federal initiatives underway.
6. In order to maintain high performing health plans and assure price competition for Mid Michigan, the Committee should join MAHP and others at the Insurance Commissioner’s November 23rd public hearing to raise these concerns.
7. The appropriate inclusion of cost-containment initiatives that will provide the overall cost savings for this proposal.

Attachments

- MAHP August 12th Letter
- Summary of Federal Health Care Reform
- Linkage to:
 - USA Families—Hidden Tax
 - AHIP Report on Cost Driver



Michigan Association of Health Plans

August 12, 2009

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Hon. Andy Dillon
Speaker of the House of Representatives
P.O. Box 30014
Lansing, MI 48909

Re: Public Sector Healthcare Reform

Dear Speaker Dillon:

The Michigan Association of Health Plans (MAHP) appreciates your efforts to reform public sector employee healthcare in the state of Michigan. A hallmark of our association is to promote managed care in a setting that achieves prudent efficiencies in the delivery of health care. It appears, based on our preliminary review, that your "Prescription for Public Sector Healthcare Reform" is generally consistent with the goals and mission of MAHP member plans. MAHP, however, has not received nor reviewed any of the vital details of the reform package or any associated legislation; and in the absence of such review, we are not able to indicate our formal position on the proposal. Any comments noted in this letter, therefore, are not intended to be statements endorsing or opposing any part of the Public Sector Healthcare Reform Proposal.

However in response to your request for comments and in light of our preliminary review, MAHP wishes to point out some key issues related to your proposal.

Key Concerns

1. Retaining consumer choice

MAHP fully supports the greatest degree of consumer choice in health plan providers. An expansive choice of health plans for consumers leads to a greater amount of competition in the marketplace and creates downward pressure on health care premiums. This high level of market competition is consistent with the efficiencies sought by your proposal to reform public sector healthcare.

As a result, a threshold concern for MAHP is that any proposal affecting public sector employees should assure that all health plans

with current enrollment be allowed to compete for the public sector business. It would be virtually impossible for MAHP to support a proposal that designates or unfairly favors any single (or subsection of the entire health plan market) health plan or health insurance carrier. We hope you share our belief that open and fair market competition is something that should be clearly set forth in any proposed legislation that may arise from your proposal.

2. **Equal market conditions and assuring competitive process**

Consistent with the preceding discussion regarding consumer choice, true competition in the marketplace can only happen when all carriers are subject to the same market conditions. Another way of characterizing “similar market conditions” is to assure that no single carrier (or segment of carriers) has an unfair advantage in the market. This is especially true as it relates to provider reimbursement rates. If one carrier has monopolistic control over the amounts paid to health care providers, then it may pay minimal reimbursements and realize savings that are not available to any other carrier. This presents an inherently unfair market advantage by one carrier being able to leverage its control over reimbursements and essentially “freeze out” competition.

One method to assure fair market competition is to establish a common reimbursement fee schedule for your proposal to reform public sector health care. If all carriers are subject to the same payment rates to providers, then vigorous competition will flourish and public sector employees participating in the reform program will greatly benefit by plans striving to provide the greatest quality of care. In that way public sector employees will be served by competition that is based on performance, quality and customer service. Indeed, we believe that public sector employees deserve the highest quality and service available and a common provider reimbursement schedule is the logical method for keeping quality care high and premiums low.

Another way to assure market integrity is to implement a competitive bidding process (based on a common reimbursement schedule discussed immediately above). If the public sector purchaser uses competitive bidding it will likely find significant premium savings.

3. **Migration of individuals and small group customers**

MAHP has been active in the current discussions regarding proposed reforms to the individual health insurance market. As you know, MAHP continues to participate in workgroup meetings held by Rep. Corriveau (regarding HB 4934 and its related bills) and Sen. Tom George (SB 579-582). We have consistently stated that Michigan needs comprehensive reform for the primary purpose of creating greater affordability and accessibility of health care coverage for all Michigan residents. The secondary purpose should be to reform the regulatory structure of health insurance.

What do we mean by “comprehensive reform to create greater affordability and accessibility?” This phrase means that more Michigan citizens should be converted from uninsured to insured. Those who currently have health coverage (especially employer-based coverage or through a federal health care program) should be encouraged to keep it, rather than migrate to a plan such as you proposed. A migration toward your proposal from those who already have coverage would likely cause an undue financial burden on the state. As a result, the more immediate goal of a public sector employee plan should be limited to qualifying public employees. This would minimize “crowd out” from the private market that might occur by opening up the program to those who currently have coverage.

4. **Retention of collective bargaining/local control of municipal employee coverage**

Collective bargaining has a long history in Michigan and it plays a large role in the purchasing of health care benefits in the group market, especially public sector groups. MAHP supports the retention of collective bargaining rights as a vital role for most local union representatives. We continue to study the proposal and as our analysis progresses, we hope to find clarification that collective bargaining rights will not be adversely affected.

MAHP also is sensitive to the concerns of local governments to retain their representative control over their business units. Of course a primary component of their respective business models is negotiation and purchase of health care coverage. And although economies of scale is logical over a wider range of governmental units, it might be advantageous for these affected governmental units to “opt in” to the proposed public sector plan. Such an “opt in” would be an especially good choice for those business units that can demonstrate a savings by joining forces with the state in the purchase of health insurance coverage.

5. **Realizing cost savings**

Page two of “The Dillon Prescription for Public Sector Healthcare Reform” states, “The State of Michigan faces a 2010 fiscal year deficit of more than \$1.7 billion. Structural changes in public sector active and retiree health care benefits provide an opportunity to help the state address this budget deficit by reducing costs by an estimated \$700 to \$900 million per year.” Although there is no doubt that the 2010 budget deficit will significant and a challenge for you and other policy makers to resolve, MAHP has reservations about the total amount of saving estimates noted in that report. Regardless of actual savings realized, we caution that you should not assume that the projected savings will occur in time to be part of the FY 2010 budget deficit solution. Considering the time constraints in implementation of the program and working out of collective bargaining rights, it will be highly unlikely for the plan, even if launched in 2010, to have any appreciable downward pressure on short-run cost/savings.

Further, while same savings will ultimately accrue due to the proposed pooling of public sector employees, we hope all observers understand that the vast majority of the proposed savings will come from the proposed re-alignment of benefit plans.

6. **Establishing workgroup and assuring procedural transparency**

The “The Dillon Prescription for Public Sector Healthcare Reform” is a wide ranging modification to a complex system of health benefit purchasing. Such a large scale proposal warrants a careful and deliberative review. Like most such reviews, it would be prudent to create a workgroup of all interested parties for a full and open exchange of opinions. MAHP stands ready to assist when and if a workgroup is convened.

The workgroup process, moreover, promotes transparency in the development of public policy. MAHP has advocated for this type of transparency, especially in the context of the current debate about individual market reform. Transparency, not only good for the development of the proposed public sector health care program, but it is also an important component of the day-to-day operation and the administration of the program. Additionally, transparency will provide interest groups with the assurance that key issues have been addressed in the development of the process and will be instrumental in the final implementation.

7. **Alignment of Goals with MAHP Mission**

Page three of “The Dillon Prescription for Public Sector Healthcare Reform” states several goals that are important to MAHP and fit squarely within mission of our member plans. One such goal is, “Aim to optimize the health of public sector employees, retirees and their families, by investing in prevention and wellness, rewarding healthy behaviors and encouraging individuals to actively participate in the management of their own health.” This goal accurately summarizes the core purpose of managed care plans and it is exactly what MAHP members perform on a daily basis. This experience of managing care makes MAHP member plans uniquely qualified to carry forward the purpose of your proposed plan for public sector health care.

Another very important goal noted on page 3 states, “Establish a mechanism to ensure that the health care delivered in Michigan conforms to recognized best medical practices.” MAHP has been in the forefront of promoting evidence based medicine. This is more than a concept, it is a practice to actively use those methods and procedures that have proven medical benefits and clinical effectiveness. Through the use of double-blind clinical trials and the use of cohorted studies, MAHP has been instrumental in providing information to members and associated medical providers on the most current treatments and those constituting best medical practices.

MAHP looks forward to receiving more detailed information regarding your proposal for public sector health care benefits. Once we have an opportunity to analyze draft legislation,

and obtain additional detail we will be better able to articulate a more definitive position.
Again, thank you your for the opportunity to comment on the proposal.

Sincerely,

A handwritten signature in black ink that reads "Rick Murdock". The signature is written in a cursive style with a long, sweeping underline.

Rick Murdock

Cc: MAHP Executive Committee

FEDERAL HEALTH CARE REFORM TIMELINES IN HOUSE AND SENATE BILLS

REFORM	AMERICA'S HEALTHY FUTURE ACT OF 2009-SENATE FINANCE	AFFORDABLE HEALTH CARE FOR AMERICA ACT—HOUSE BILL
Health Insurance Rescissions	Prohibits beginning in January 2013.	Prohibits beginning in 2010.
Limits on Pre-existing Conditions	Prohibition beginning in January 2013. Within a year of enactment creates a high risk pool for individuals with preexisting conditions.	Complete prohibition beginning in 2013. Beginning in 2010 reduces the window that plans can look back for pre-existing conditions from 6 months to 30 days and shortens the period that plans may exclude coverage of certain benefits.
Guarantee Issue	Requirement beginning in 2013.	Requirement beginning in 2013.
Individual Mandate	Establishes an individual mandate for health insurance beginning in 2013. Penalties are phased in according to the following schedule: \$0 in 2013; \$200 in 2014; \$400 in 2015; \$600 in 2016; and \$750 in 2017.	Beginning in 2013 requires individuals to obtain acceptable health insurance coverage or pay a penalty of 2.5% of their income that is capped at the cost off the average cost of qualified coverage.
Ban on Lifetime Limits	All plans operating in the Health Insurance Exchange are prohibited from placing lifetime caps on coverage.	Prohibits insurance companies from placing lifetime caps on coverage in 2010.
Employer Responsibility	Employers are not mandated to provide coverage but employers with more than 50 employees that do not provide coverage would be assessed a fee beginning in 2013.	Beginning in 2013 employers are required to offer coverage or pay a penalty of 8% of their payroll. Small businesses with annual payrolls below \$500,000 are exempt.
Health Insurance Exchange	State based health insurance exchanges will be established as early as 2010.	In 2013 health insurance exchanges would be open to individuals without other coverage and to small employers with 25 or fewer employees.
Medicaid Expansion	January 2014 up to 133% FPL	January 2013-up to 150% FPL
Public Health Insurance Option	N/A	Creates a new public health insurance option that is available within the Health Insurance Exchange in 2013.
Health Care Cooperative	The proposal authorizes federal funding for the Consumer	N/A

FEDERAL HEALTH CARE REFORM TIMELINES IN HOUSE AND SENATE BILLS

	Operated and Oriented Plan (CO-OP) program beginning in January 2012.	
Increases Reimbursement for Primary Care in Medicaid		Phases in an increase in Medicaid reimbursement for primary care services beginning in 2010. Medicaid primary care services would be reimbursed at Medicare levels with 100% federal funding.
Enhanced FMAP for States with High Unemployment		Extend the current Recovery Act increase in federal Medicaid payments to states with high unemployment an extra 6 months thru June, 2011.
Premium Subsidies	Beginning in 2013 refundable tax credits would be available to individuals and families with incomes between 133 and 300% of the FPL who purchase insurance thru the exchange. Additional cost sharing subsidies would be available to individuals between 100-200% of the FPL.	Beginning in 2013 health insurance affordability credits will be available for people with incomes above Medicaid eligibility and below 400% of the FPL.
Small Business Tax Credits	Beginning in 2011, small employers with fewer than 25 employees and average wages of less than \$40,000 that offer health insurance would be eligible for a tax credit. In 2013 the credit would only be available to employers that purchase insurance coverage through the Exchange.	Beginning in 2013, tax credits will be available to small businesses that choose to provide health coverage. The credit could be worth up to 50% of the amount paid for employee health coverage.
Medicare Advantage	Beginning in 2014 MA benchmarks will be based on the weighted average of plan bids. The benchmarks will be transitioned in starting in 2011.	Beginning in 2011, reduces MA payments over 3 years to achieve parity with 100% FFS rates.
Excise Tax	The bill imposes an excise tax on high premium health plans for tax years after December 31, 2012.	N/A
Provider Taxes	The bill imposes taxes on the insurance industry (\$6.7 billion),	A 2.5% tax on the sale price of all medical devices effective for the

FEDERAL HEALTH CARE REFORM TIMELINES IN HOUSE AND SENATE BILLS

	manufacturers of prescription drugs (\$2.3 billion), manufacturers of medical devices (\$4 billion), and clinical laboratory services (\$750 million). These taxes would begin in January 2010.	2013 tax year.
Surcharge on High Income Tax Payers	N/A	The bill would impose a 5.4% surcharge on taxpayers with adjusted gross income in excess of \$1 million (married filing a joint return) and \$500,000 (single). Effective for all tax years ending after December 31, 2010.



Michigan Association of Health Plans

WEB LINKAGE TO OTHER REPORTS REFERENCED IN MAHP TESTIMONY

1. USA FAMILIES—HIDDEN TAX

www.familiesusa.org

2. AHIP—REPORT ON COST DRIVERS

<http://www.ahip.org/content/default.aspx?docid=25127>



Michigan Nurses Association

The Power of $>$ One
more than

Testimony of Ken Fletcher
Associate Executive Director, MNA
In opposition to House Bill HB 5345
November 5, 2009

Good Afternoon Madam Chair and Members of the Committee

I am Ken Fletcher, Associate Executive Director of the Michigan Nurses Association and I have with me here today Katie Oppenheim, RN, who is chair of the University of Michigan Professional Nurse Council. Thank you very much for giving us the opportunity to comment on why we are opposed to House Bill 5345, the speaker's mandatory state run health proposal for public employees.

We are interested in this legislation for a couple of reasons. As health care providers, we have concerns about how this proposal will impact the health care for over 1 million Michigan citizens. We also have concerns about this proposal because we have members who will be forced into this mandatory state run plan. Our largest bargaining unit is the University of Michigan Hospital, whose employees would be covered by this bill. We also represent nurses in numerous public health departments throughout the state. All of these nurses will be forced into this plan.

Let me begin by stating that the Michigan Nurses Association is committed to the principle that health care is a human right and that all persons are entitled to ready access to affordable, high quality health care services that are delivered in a safe, effective, patient centered, timely, efficient and equitable way. This is the yard stick that we use to measure all proposed reforms of our health care system.

We have concerns that House Bill 5345's main objective isn't to extend health care coverage to people who don't have care, or to improve care for those with inadequate care. Its objective seems to be to set up a structure that will make it easier to reduce the health care coverage for over 1 million Michigan residents who already have good health care benefits.

Under HB 5345, our nurses who work for public employers will no longer have a say in the design of their health benefit plan. Currently that is an issue that is negotiated at the bargaining table. We can negotiate over coverage and providers. We can make sure that our health plans include things like wellness programs and an emphasis on primary, preventative care. We can fight for programs to help us manage chronic diseases. We can also negotiate to ensure things like mental health parity.

You may argue that HB 5345 instructs the new Michigan Health Benefits Board to take all those issues into account when crafting their mandatory plan. However, under HB 5345, it's not our members who get to decide those issues for themselves; it's the 13 member board that makes those decisions. Our members will be left on the sidelines hoping that the board makes decisions that will be in their best interest.

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United American Nurses • AFL-CIO

A good example of our concern was the response that Ms. Kate Kohn-Parrott gave Chair Byrnes when you asked about mental health coverage. Ms. Kohn-Parrott replied that it would be up to the board to decide those issues. Well, what if they make the wrong decision? Our members' lives are literally impacted by the decisions of this board. We don't want to delegate that much power to a group of unelected people.

The bill calls for there to be 4 representatives of public employees. However, there is no guarantee that anyone of those 4 will be one of our member nurses from U of M Hospital or one of our public health department nurses.

Under HB 5345, we have no way of knowing what the health plan will look like until after it's been approved by the board. Some have said the board will offer a "Chevy version", a "Cadillac version" and a couple of versions in between those options. There is nothing in HB 5345 that guarantees any of that. All of the options could be a pared down plan that is decided primarily on cost. The board could even decide to have only one plan available.

We have serious doubts that HB 5345 will save Michigan between \$700-900 million without reducing the health benefits that are provided to public employees. There is not that much to be gained by administrative savings. The savings will have to come by reducing benefits. Many of the proponents of this proposal actually state the need to reduce public health benefits as one of the main reasons why they support HB 5345. They obviously feel that is the primary goal of HB 5345.

Ms. Kohn-Parrott also said prescription drugs would be one area of savings. I remember when Ms. Kohn-Parrott was with Chrysler and the Big Three forced all their workers and retirees to stop going to their local pharmacies for their prescriptions and made them all go to out-of-state mail order companies. Lots of local businesses were very seriously impacted by that decision. Are those the type of changes the board will make?

Let's not forget that this proposal doesn't save any money in the short run and has some pretty expensive startup costs. Where does the state find the money for those costs when you are looking at the next round of devastating budget cuts? Now is not the time to waste money on an experiment.

This proposal really isn't new. The Senate Republicans proposed the same thing back in 2004 and had the HayGroup out of Virginia do a report that said you could have big savings by cutting benefits and increasing employee cost sharing. The only difference between the Sikkema/Johnson proposal of 2004 and the Dillon Plan of 2009 is that this plan includes all public employees.

The only way that this bill can be fixed is to make participation in the state run plan voluntary. That way you would be preserving local control and collective bargaining rights and you would be offering local governments and schools another choice. That should be a key goal of any reform – giving people more choices and more control over their health care.

I would also include more direction on the level of benefits that should be included in the health plans that are created by the board. The size of the board also needs to be increased to include more health care providers, especially nurses. If you are confident that the board can design a good plan that saves money, then people will want to participate. There is no need to mandate participation and strip workers of their collective bargaining rights.

Again, thank you Madam Chair for this opportunity to testify on this important subject. I will turn things over now to Ms. Oppenheim to talk about her experiences negotiating on behalf of nurses at U of M Hospital.

**SERA PRESENTATION TO THE
PUBLIC EMPLOYEES HEALTH CARE REFORMS COMMITTEE
By Robert Kopasz**

Thank you, Madame Chairwoman and members of the Committee. My name is Robert Kopasz and I am Chairperson of the Michigan State Retirees Association Coordinating Council, commonly known as the SERA Council. With me today is Alvin Whitfield, SERA's Legislative Committee Chair.

First, please allow me to tell you about SERA. It is an organization composed of some 14,000 retired state employees and/or their spouses dedicated to advocating for and protecting the pensions and benefits of retired state employees. We have twenty-one chapters throughout the state extending from Lapeer to Muskegon and from Adrian to Marquette. Our membership is very diverse in terms of political orientation and occupational talents. Our membership ranges from retired doctors, lawyers and secretaries to janitors, power plant operators and automotive mechanics, just to name a few. The commonality of our group lies in the fact that we are proud retirees of the State of Michigan seeking to maintain and maximize the purchasing power of our pensions and not having it eroded through increases in our health care costs.

It should be noted that there has been a paradigm shift in the emphasis of SERA in carrying out our mission in recent years. For many years, our primary focus was on securing adjustments in the pension of selected groups in our organization. Essentially, we were interested in obtaining increase adjustments in the pensions of those older state retirees who because of the good fortune of longevity have seen the spending power of their pensions eroded. As you know, pensions are based on years of service and final average compensation multiplied by a factor. Those members, who in the sixties, seventies, and eighties had much smaller salaries on which their pensions were based, are now seeing inflation erode the spending power of those pensions. While we were successful in obtaining a pension adjustment for pre-1987 retirees some twenty-two years ago, we have been unable to obtain subsequent needed adjustments. Thus, a number of older retirees are really hurting financially.

But with the alarming increases in health care costs, we have shifted our organizational emphasis from fighting for pension increases to protecting the health care benefits of our members and preventing the erosion of their pensions through additional co-payments and co-insurance. As we all know our pensions are constitutionally protected from being diminished. However, there is no such protection afforded retirees from having the spending power of their pensions diminished by significant increases in the co-payments and co-insurance related to their health care benefits. A relatively small percentage increase in the amount of these items can have a significant impact on the spending power for other necessities of life for many of our members. We believe the State of Michigan has a moral obligation to fulfill the "Promise" that was made to now-retired employees of the State while they were active employees. Abandoning the "Promise" in the twilight years of a retiree's life is, in our opinion, unconscionable. One of our major concerns about HB 5345 is that it may have unintended consequences which will work to the detriment of SERA members.

From our understanding of HB 5345, it is written primarily from the standpoint of active unionized employees. The bill does not appear to address the concerns of current state retirees who have no official advocate in the health plan selection and cost determination process. Health benefit plan design is critical.

The state retiree health plan design has for decades been tied to the health plan in effect for active state employees. Even so, SERA's input is sought and considered prior to final health care plans for retirees being authorized by the Department of Management and Budget and the Civil Service Commission. We, as an organization, have an ongoing dialogue with Civil Service and the Office of the State Employer staff regarding any issues or concerns. While our opinions and concerns may not always be accepted, we know that they are seriously considered and we are given an explanation of how and why final decisions were made. This interaction permits us to better inform our members and gain their acceptance of changes in plan design and cost impacts. Our input has been sought by the Civil Service Commission for various changes in Healthcare coverage, examples include: 1) In 2003 changing the State Health Plan basic/major medical to the State Health Plan PPO (saving over \$20 million annually), 2) In 2004 the State introduced the Support Program for durable medical equipment (estimated savings of over \$5 million to date), 3) In 2006 a Medicare Part D subsidy program was implemented for retirees (savings averaging \$22 million annually), 4) In 2008 the State moved to a Medicare Advantage Plan (estimated savings of over \$40 million), 5) In 2009 increases in co-pays, deductibles and premium increases resulted in savings of nearly \$47 million for retirees alone. These savings total nearly \$280 million that the State has saved over the past 8 years. We have provided input and worked closely with Civil Service staff to communicate and explain to state retirees any and all health care changes to the State's Health Plan.

Contrast this method of input by our organization to what it will be under HB 5345. Our members will not be represented by unions in the negotiating process. We will be part of a huge group of public agency retirees whose health benefit plan selection and costs will be determined by a nameless and faceless group of individuals who are isolated from input from our membership by a politically established board consisting of only one representative for all retirees. The institutional knowledge regarding those factors that may impact the current level and costs of benefits will be meaningless. For example, the fact that the most elderly and vulnerable state retirees have not had a pension adjustment in 22 years will be irrelevant in determining the cost and plan design of the plan that is chosen for them. Nor will the fact that state employees who are now retired gave up various pay increases through the years in exchange for health care enhancements.

House Bill 5345 and the "white paper" speaking to this Public Employee Health Plan refer to various programs that should be included. It should be noted that most Active state employees and retirees participate in most of those plans at the present time. In the Prescription Drug area we participate in the following: Generics preferred, Drug Quantity Management, Specialty pharmacy, Prior Authorization, 3-tier drug plan (\$10, 20 & 40 co-pay retail and \$20, 40 & 80 mail-orders). In the State Health Plan the following programs are included: Preventive Services (Physical exams, Immunizations, Blood screening, Mammography, Colonoscopy, PSA etc.), Weight Loss Benefit, Cardiac Rehabilitation, Diabetic training, Coordinated Care Management (Asthma, Diabetes, Congestive Heart Failure & Ischemic Heart Disease), Support Program (Durable Medical Equipment), Wellness, Smoking Cessation and Disease Management.

When I discussed my appearance before this Committee with committee staff, I was asked whether we supported or opposed HB 5345. My response at that time was that we neither supported nor opposed it because there were too many questions/issues remaining to be answered and resolved. The following are some of the questions/issues we believe need to be answered in order to allow a complete and shared understanding of the pooling concept embodied in HB 5345:

The opinion of the Legislative Service Bureau legal staff suggests that the bill may be unconstitutional as it applies to state employees/retirees in that the approval of compensation and benefits for this group is the

sole responsibility of the Civil Service Commission. We would strongly encourage this Committee to clarify and settle the constitutional question as it relates to state employees/retirees raised by the LSB attorney as soon as possible. It would be impossible for me to convey to you the level and degree of anxiety that exists among our most elderly members over the issue of their health benefits caused by the introduction of HB 5345. It is needless and inconsiderate to put these elderly individuals through this high level of concern if HB 5345 is not applicable to them.

The bill allegedly will create a \$900 million savings. How realistic and accurate is this purported saving and to whom will the saving accrue? I believe Mitch Bean of the House Fiscal Agency suggested it would require actuarial experts to drill down and verify the soundness of the \$900 million dollar figure. Obviously the significant savings is the driving force behind the bill, so this is a critical factor for which there should be a definitive answer regarding its soundness and viability. This issue appears to be a threshold decision point. Adding to the confusion and anxiety of state retirees is a report prepared by Public Policy Associates, Inc. a respected national research firm. The report's findings (by Researcher Doug Drake) is diametrically opposite in terms of the amount of savings generated by the pooling concept. A comparison of the two reports indicates a \$1.7 billion dollar gap in the amount of savings to be generated. We would hope that actuaries and/or other independent experts could review how the savings figure was arrived at and make an initial determination of its soundness before the bill is acted upon. Parenthetically, we are at a loss as to why there has been no legislative fiscal agency analysis done on HB 5345 as is normally done when a bill reaches this stage in the legislative process.

Another concern/issue about this plan is whether or not government entities that currently do not provide health benefits for employees/retirees will be forced to do so? If so, where will these entities obtain the funds to address these benefits?

Another lynchpin in the concept embodied in HB 5345 is that creating a larger pool of employees/retirees would enable vendors to give greater cost reductions as a result. As we understand pricing structures, there are various plateaus established between which no cost reductions are realized until the next plateau is reached. Hopefully, there is evidence that having over 400,000 individuals in the health care pool is well above the threshold level for the realizations of additional savings. Again, it would appear that actuarial experts could confirm the veracity of this concept.

The issue of unfunded liability appears to be a very complicated one. Each of the governmental entities will have various levels of unfunded liability. How will the pooled plan assure that the unfunded liability of each entity is eventually funded and that the financial structure for the pooled group of employees/retirees will be fiscally sound and not create a problem of gigantic proportions in future years? Will one of the unintended consequences of HB 5345 be a tremendous financial drain on the State of Michigan? This is a question of paramount importance.

As you can see, SERA still has some serious misgivings about the viability of HB 5345. While we have not taken a position either in support or against the bill, we have a healthy degree of skepticism. It is our belief that a bill with a myriad of complexities as this one should not be rushed but move slowly and with extreme caution. It should be carefully and thoroughly vetted by attorneys, financial, and actuarial experts. We would suggest that the experience of other states in pooling should be cautiously examined to make sure that there is a sound basis for any comparisons made between those states and the State of Michigan. cursory comparisons of cost alone without looking in-depth at the details such as similar structures, plan designs, laws, financing, etc. could be fatal.

I sincerely hope this presentation has positively contributed to the dialogue regarding the viability of HB 5345. Given the several unanswered questions and our expressed concerns, SERA must withhold support of HB 5345 until such time as a clearer picture of the resolution to the issues raised emerges. It would seem that there should be other legislation (yet to be introduced?) that may have an impact on this far-reaching concept. Perhaps the introduction of the complete package of bills in support of HB 5345 will serve to clarify some of our concerns. We will continue to watch the progression of this bill.

We would be pleased to answer any questions you may have.



Thank you Madam Chair for the opportunity to testify today on the issue of health care insurance for public employees. My name is Bill Anderson and I represent the Michigan Townships Association.

Health care costs impact different townships in significantly different ways. According to our survey of the 1,240 townships in Michigan, we estimate that townships employ approximately 7,500 individuals on a full-time basis and approximately 20,000 people on a part-time basis. Most of the part-time employees are protecting 90 percent of the land mass of this state from fires.

In some cases, the chief concern of the township is dealing with police and fire unions and their impact on township operations due to the binding arbitration issues contained in Public Act 312. In many more cases, local townships struggle to find insurance plans that offer reasonable coverage at reasonable prices in much the same manner as any other small business. For those townships, it is not a union issue; it is simply an employer issue. MTA tries to assist townships by providing access to insurance in cooperation with the Michigan Municipal League through a pooled health care plan. Approximately 10 percent of all townships in the state participate in this plan with the vast majority of those townships insuring less than 10 employees. Finally, the majority of the townships in the state deal with health insurance in the most economical manner possible, they don't offer the benefit. For many townships the cost of health care simply excludes consideration of this benefit. This is especially true when the only employees are the elected officials who are for all practical purposes the entire office staff.

Many people, including the governor, are talking about the virtues of pooling for health insurance or cooperative efforts to achieve this health care goal. When the Speaker's proposal first came to public light the governor's press secretary distributed a letter to the editor that pointed out that local governments could already enroll in the state employee health insurance plan. The civil service commission modified their rules three years ago to allow local governments into the state health plans, with one very serious limitation. Local governments can only participate in the program so long as they pay 100 percent of the cost of the coverage. In asking for an interpretation of this limitation, I was informed that if a township had an employee who had a catastrophic event that caused more to be paid out in benefits in any particular year than taken in from premium payments, the township would owe the state 100 percent of the difference. In essence, this would be like operating a self-insured plan for five or ten people. Of course, the township would receive no refund if our employees received fewer services than the amount paid in premiums. I believe this would qualify as a lose – lose scenario.

MTA is looking for options for its membership to provide health care that is a quality plan at affordable prices. What is maybe even more important, at a stable price!

Much effort in the white paper is placed on comparing the cost of insurance for Michigan public employees to other benchmarks. Most of the analysis is focused on who pays what share of the

SERVING 1242 TOWNSHIPS AND 6500 OFFICIALS

premium cost. Section 9 of HB 5345, would require the board to approve health plans that are comparable in price to premiums paid in similar states.

It is interesting to note that the cost of health care is not even uniform in Michigan. I have already had discussions with local governments from the west-side of the state that contend that their insurance costs are lower than those who operate on the east-side. Those officials are worried a single plan will lead to cross subsidies in our state. So what factors would this board need to review to create parity between states when we don't have parity in our own state?

The cost of insurance has a lot to do with how much we pay our health providers. Generally, we rely on the power of insurance companies to negotiate compensation agreements to establish this cost. What is the actual cost of compensation for services in our state compared to other states? Do our insurance carriers strike as tough a bargain as carriers get in those other states? Is the fee we pay to those insurance companies to negotiate those deals comparable to what other insurance companies get in other states? Are we having problems getting good deals with health providers because they need to compensate for greater Medicaid or Medicare caseloads as compared to other states, or for that matter unreimbursed health care? I don't know these answers, but they must be addressed to evaluate this legislation.

Once we get past how much we pay for a service in our state, then we need to look at how often we make use of those services. What is the quantity of health care services consumed in this state as compared to the other states? If we are consuming more health care services, of course the plans will be more expensive.

The testimony over the past few weeks has been very interesting and helpful in understanding the direction of this legislation. Frankly, it has helped me get my arms around the objectives. The proposal focuses on a more active administrative role to create healthier lifestyles to bring down costs. Frankly, this is hard to argue against as an objective, just as is the case in trying to manage prescription costs through a critical review of the cost and benefit of drugs on the market. I see this as a very positive discussion. I still see the need to flesh out what this strategy will mean in terms of administrative costs.

The theme of the testimony to this point is that quantity of use of health care services has a lot to do with how the plan is structured. Do plans with very low copayment and deductibles or broad coverage application lead to active preventative care saving the system from more expensive solutions in the future or do they spawn unnecessary usage. A perfect example would be plans that cover eyeglasses. Some plans allow a person to replace their glasses once a year and some once every two years. Those people with the more liberal coverage often make use of the replacement option regardless of need. Low copayments and deductibles can skew use by eliminating much of the personal consumer economics from the health care choice. This legislation would seem to be very dependant on using the copayment and deductibles as well as potentially the premium copayments as a steering system to make good health care choices.

Another major issue regarding the usage of health care was referred to in previous testimony. Many employees are part of two income families, families that have the possibility of receiving health insurance from both employers. This is the situation in my family. We have options on how to insure our family and we make our decision in a manner that financially best benefits the family. If you as an employer have very low premium copayments and low copayments and deductibles, a disproportionate number of families will opt to receive their insurance through you and your organization will pay more than the norm for health care on a per employee basis; this is simple economics. This issue is likely to become much more acute as unemployment pushes total costs onto the plan of the one person who is still working. It will also shift as many employers continue to reduce benefits that they offer their employees. I see a scenario in this state where public employee health care plans are going to see greater usage for the next few years as the last safe haven for many families during these difficult economic times.

The final differentiation between plan costs, and the one that makes the greatest difference in the least amount of time, is the copayments and deductible required under the plan. If you want to reduce the premium cost of an insurance plan by \$1000; increase the deductible by the same amount. Want to cut the premium by 20 percent; require a 20 percent copayment on all services. Trying to benchmark Michigan health care costs against other states without evaluating the impact of copayments and deductibles would be inappropriate.

Here is the problem I have observed between testimony, written materials and miscellaneous comments. I have often heard the comment that we do not intend to shift costs to employees. Language in the bill states that premium copayments will be decided locally. Comments from committee members indicate that copayments and deductibles would also be negotiated locally. However, much of the testimony regarding bringing down prescription costs and creating incentives to receive appropriate health care are very focused on using financial incentives or disincentives to modify consumer behavior. How do you negotiate copayments and deductibles when the entire programs chance of success is dependant on that decision?

The one issue that really stands out to townships on this plan is the mandate associated with its implementation. Why is there concern? Township officials are being directed to do business with an organization that does not exist at this point; they have no ability to leave the plan if it does not meet expectations for service or cost and there is no guarantee of cost savings. The challenges of identifying all local employees, educating them regarding the change and insuring that they don't get "lost in the system" is going to be a major undertaking, especially as resources at the state level dwindle. This plan asks for a lot of trust to be given to the state. Trust is a rare commodity these days.

I represent a group of governments that will flock to a well run plan that offers competitive prices. We have no emotional ties that bind us to a particular health plan. The state currently controls the health care plans for 250,000 families and probably over half a million citizens. The state doesn't need mandate local governments to participate in this program to successfully implement the plan as I have heard it

described. State government receives no direct benefit from the mandate. If this plan is as good as advertised, local township employees will be knocking on your door to join.

My other comments on reading the legislation are as follows:

Section 3 creates this health care entity within the Department of Management and Budget. My true concern in organizing this as a state operation is found in Section 19. The statute would provide that none of the funds in the health system would lapse into the state general fund. This could be changed in the future with a simple amendment to the law. I am also a bit concerned because any reserves are held as state funds. Does this create a scenario where the system could require larger reserves in order to assist the state's short term cash flow position? Is this system better off being established in a more autonomous authority manner so such issues do not come into question?

I encounter repeated references to creating a single state plan. From the bill and public statements, the single state plan will be offered through multiple forms of insurance including: HMOs PPOs, and other forms. The single state plan is likely to be offered by multiple providers to maintain health care competition in the state and it might have differential rates to accommodate regional differences. Add in the issue of premium cost sharing and locally determined copayments and deductibles and now we have just as many plans under this one state plan as we have today. We already know the state employee plan is actually 15 different choices, so is this system likely to be significantly different? If savings are accrued from having one plan, how does this concept of multiple plans impact those assumed cost savings?

Other state laws differentiate vision and dental care from health care. This proposal does not seem to venture into the realm of dental and vision insurance, it also does not mention fee for service type insurance plans as opposed to HMOs and PPOs. Are we to assume that traditional coverage will not be part of the plan nor dental and vision coverage?

Thank you very much for your time, this concludes my observations of the issues that present themselves within this very important concept to this point in time. I would be happy to answer any questions from the members of the committee.